JUDICIARY OF
ENGLAND AND WALES

R v SOUTHERN HEALTH NHS FOUNDATION TRUST

SENTENCING REMARKS

In the Crown Court Sitting at Oxford

Mr Justice Stuart-Smith

26 March 2018

Introduction

1. The Defendant has pleaded guilty to two offences contrary to s. 3(1) of the Health and Safety at Work Act 1974. The particulars of the offences are as follows:

   a. "That you on and before 22 April 2012, being an employer with the meaning of the Health and Safety at Work etc. Act 1974 (the Act) failed to discharge the duty imposed by Section 3(1) of the Act, in that you failed to conduct your undertaking in such a way as to ensure as far as was reasonably practicable, the safety of persons not in your employment who may be affected thereby, namely patients including Teresa Colvin, by failing to protect patients from the risk of serious self harm, in that ligature points and ligatures were present in a range of premises, ….."; and

   b. "That you, between 18th day of March 2013 and 5th day of July 2013 at STATT Slade House, Horspath Driftway, Oxford, …, being an employer within the meaning of [the Act] did fail to discharge the duty imposed by Section 3(1) of the Act, in that you failed to conduct your undertaking in such a way as to ensure as far as was reasonably practicable, the safety of persons not in your employment who may be affected thereby, including Connor Sparrowhawk, in that such persons were exposed to the risk of drowning from bathing, …".

2. Two things are immediately apparent. The first is that lying behind each of these summonses lies the story of an unnecessary human tragedy. One concerns Mrs Teresa Colvin, who everyone has referred to as TJ; the other concerns Mr Connor Sparrowhawk, who everyone has referred to as Connor. I shall respectfully follow their lead. The second is that the offences relate to events that happened five or six years ago. These two features are interrelated as I shall explain.

3. It is a regrettable fact that it took a time consuming and punishing campaign on the part of Connor's mother and stepfather, Dr Sara Ryan and Dr Richard Huggins, and TJ's husband, Mr Roger Colvin, and others to uncover the serious systemic problems with the Trust's health and safety management arrangements that underpin this prosecution. Those systemic problems lasted for years from well before the death of TJ until well after the death of Connor. The existence of those problems is now fully acknowledged by the Trust, as I shall detail later. However, it is clear on the evidence that Dr Ryan in particular faced not merely resistance but entirely unjustified criticism as she pursued her Justice for LB campaign – LB being short for "Laughing Boy", which was Connor's widespread and affectionate nickname. It is right that I should pay tribute to those who campaigned but in particular to Dr Ryan at the outset of these sentencing remarks. It is also right that I should record the Trust's public statement that:

> "The Trust fully acknowledges that Dr Sara Ryan has conducted herself and the Justice for LB campaign in a dignified, fair and reasonable way. To the extent that there have been comments to the contrary by Trust staff and family members of staff, these do not represent the view of the Trust and are expressly disavowed."

4. When the systemic problems were finally recognised, a welcome realism entered the Trust's appreciation of what had happened. The Trust indicated its intention to plead guilty to these two charges even before proceedings were issued. Appropriate credit will be given for that early indication in due course. The Trust has also made it completely clear that it does not attempt to shift or deflect responsibility for what went wrong onto individuals in its employement. What went wrong went far deeper than that: this case is concerned with deep rooted systemic failings directly affecting the safety of vulnerable and disadvantaged patients. They were patients who were in the Trust's care and who needed, above all else, the Trust to protect them.

The TJ Charge

5. TJ died on 26 April 2012 after an entirely avoidable incident that occurred four days before on Winsor Ward at the Trust's Woodhaven Adult Mental Health Hospital in Southampton. She had a long history of recurrent severe depression and had symptoms of severe post-traumatic stress disorder since 2007. One of the consequences of her illness was intermittent high risk behaviour with a history of self-harm and suicidal ideation. She had previously been admitted to Woodhaven, though she had not been an inpatient for about 12 months before April 2012, and the staff there knew her well. There had been a period of alcohol dependence, though by 2012 this aspect of her condition had receded and she had become a heavy user of benzodiazepines.

6. During the period leading to 20 April 2012, TJ was being cared for in the community, by the Trust. On that day she was found by her husband at home, muttering to herself,

with a bag over her head and a belt around her neck, as an apparent response to hearing voices. She was admitted to Woodhaven on a voluntary basis.

7. On admission, TJ was placed on 15 minute observations, which was the regime that was maintained throughout her final stay. The question whether to change the regime was a difficult one involving finely balanced medical judgments and the decision not to change the regime is not criticised. That said, her behaviour continued to be both troubled and troubling. On 21 April she went missing and was found by a member of the public on the edge of a motorway bridge. She was brought back by the combined efforts of the member of the public and a police officer. Later the same day she absconded from the ward by climbing over a fence. After that, it was clear to her doctors that "it was not safe for her to leave the ward"; and in the light of an assessment of increasing risk, she was lawfully detained on the ward under the Mental Health Act. While on the ward, during the morning of 22 April 2012, there was a further episode when she placed a bag around her head and headphones around her neck; and there was more than one incident of her cutting herself in different places, including inflicting multiple cuts to her wrists with a broken mug, which was discovered early in the afternoon of 22 April 2012. She was clearly very disturbed and vulnerable.

8. There was a payphone kiosk on the female section of the ward, to which patients had access. It was out of clear view, which made observation difficult. It should have been identified as a priority area when checking on the welfare of patients. It was not. To make matters worse, the phone had a 33.5 inch long robust cord between the wall-mounted instrument and the handset, which presented an obvious and identified ligature risk.

9. The risks presented by ligatures in many settings have been well known at all material times. They are particularly acute in psychiatric hospitals, for obvious reasons. The risks were well known to the Trust. Between 2007 and 2011 over 1,700 ligature incidents occurred across the Trust. Fortunately, the great majority of them did not cause serious harm and most involved patients creating their own ligatures rather than using fixed ligature points, such as presented by the payphone: but the risk of serious harm or even death was well known. The risk of ligatures being created from phone cords was also well known. Between 2007 and 2010 there were more than 10 ligature incidents where patients used phone cords to create the ligature.

10. In or about November 2011 the Trust carried out an assessment of ligatures or potential ligatures on its premises. There are justified criticisms about the carrying out of this assessment but it identified the phone cord in question as a risk. The assessment was meant to apply a scoring system to each identified risk. Under that system, a score of 501 or more would represent an unacceptable risk score and would require urgent consideration as to if/how the risk could be removed or reduced. A score between 251 and 500 would represent a medium risk and should be reduced if possible. The phone cord in question was assessed as having a score of 300. It is agreed on all sides that this was simply wrong and too low. The prosecution maintain

that it should have been allocated a score of 2000,the highest possible score under the system, because it satisfied all the highest criteria for risk. The Trust accepts that it should have been more than 300. While disputing that the proper score was 2000, it does not put forward any alternative figure. For present purposes it is sufficient to say that correct application of the scoring system suggests a score of 1000 or more. On any view, it should have been given urgent consideration to see if or how the risk could be reduced. Had that been done, it would have been discovered that the cost of eliminating the risk would have been a mere £55. As the Trust now accepts, the specific risk to potentially self-harming patients on this ward should have been recognised long before 2012. As it was, although a score of even 300 should have caused the risk to be reduced, nothing was done.

11. I shall refer later in these remarks to the Trust's acceptance of the serious and systemic failings that affected it in 2011-2013. It is a feature of the TJ charge that the Trust had been specifically warned of the risks it was taking. Mr Michael Holder had been employed as Head of Health and Safety for the Trust from November 2011 until he tendered his resignation on 13 February 2012. During his tenure and on his resignation he made very serious and well-founded criticisms of the Trust's failures in its attitude to its existing health and safety management systems, which he described as "dysfunctional". In relation to ligature risks he wrote on 21 February 2012:

    > "… it has been identified that assessments are not undertaken in accordance with Trust policy, that they would not be construed as "suitable and sufficient" with regards to Regulation 3 of the Management of Health and Safety at Work Regulations 1999. Many of the risks identified have not been adequately managed in accordance with the principals of prevention detailed within Regulation 4 of [those Regulations].

    In the course of his correspondence in February 2012 he expressly drew attention to the need for the Trust to improve its management of ligature points and to help provide a safe environment for vulnerable patients. His warnings were not heeded.

12. Shortly after 6pm on 22 April 2012, TJ created a ligature using the payphone cord and suspended herself from it. She was found sitting unconscious, though still with a weak pulse. She was taken to Southampton General Hospital, where everything possible was done to help her; but she had suffered severe brain injury caused by oxygen deprivation and life support was withdrawn. She died on 26 April, aged 45.

13. Enquiries soon revealed deficiencies in the ligature risk assessment, including the absence of a date or verifying signatures. A Critical Incident Review Report in July 2012 identified the need for ligature risk areas to be identified as priority areas for staff carrying out observations on patients and that significant changes in a patient's presentation should be dealt with in the patient's risk assessment, which had not happened in TJ's case. Despite this, no thorough review of procedures or of Health and Safety management was undertaken. It was only after an independent review, known as the Mazars Report was published in December 2015 that the full scale of the

Trust's problems became clear. The Mazars report reviewed 722 "unexpected" deaths amongst patients with psychiatric problems or learning difficulties in the Trust's care. In the light of the Mazars report the HSE reviewed 91 cases where the deceased was an inpatient. Its investigation identified the case of TC and of Connor as disclosing substantial breaches of health and safety legislation, which led to the laying of these charges.

14. The investigation identified the following matters of concern, all of which are accepted by the Trust. The HSE summarises its criticisms in terms that are broadly accepted by the Trust, as follows:

    1. As a matter of fact, the Trust failed to ensure TJ's safety.
    2. It permitted a robust ligature in a ward in which there were likely to be patients with self-harming risks.
    3. The fact that the ligature was in a relatively private, rarely observed, part of the ward intensified the risk.
    4. The Risk Assessment process concerning ligatures was flawed in a number of respects.
    5. There was no Risk Assessment which addressed the hazard of self-harm using telephone cords – the risk was simply pointed out.
    6. Management did not provide appropriate supervision, monitoring, audit or governance in relation to the carrying out of the Risk Assessments or taking action to respond to known risks.
    7. There was a notable failure to respond to the series of previous incidents and wake up calls.

15. I shall return to the Trust's response after outlining the facts relating to the Connor charge.

16. In a moving statement that he read to the Court, Mr Colvin referred to life's "what-ifs" and to how every day something will trigger a memory, accentuating his terrible loss. He expressed the hope that TJ would not be just another statistic. It may safely be said that he need not worry on that score. Her sister, Wendy Andrade, referred to anger and hurt that is still very raw for the family and the massive void that TJ's death has left. These statements were eloquent in their simplicity and ensure that we never forget the human cost of institutional failings.

The Connor Charge

17. Connor was just 18 wen he died on 4 July 2013 whilst a patient at Slade House, a Short Term Treatment and Assessment Centre at Headington in Oxford, which the Trust had taken over on 1 November 2012. He was a young man who suffered from learning disability, autism and epilepsy. Epilepsy is common amongst those with significant learning disabilities and the risks it carries are well known. They include a well recognised high risk of drowning if a person who is in the water suffers a seizure. Connor suffered both from tonic clonic seizures and also from absence seizures. His epilepsy was not well controlled during 2013. It is well known that medication is

often less effective in controlling epilepsy where the person suffers from learning disabilities.

18. In early 2013 Connor started behaving uncharacteristically, on occasions showing aggression towards his mother. On 5 January 2013 he suffered a seizure which was properly to be regarded as a consequence of the introduction of Fluoxetine. On 19 March 2013 an on-call community registrar had carried out a home visit and assessed Connor to be a risk to himself and to family members. He was therefore admitted to Slade House as an emergency. The admission was initially voluntary but was turned into a compulsory one on 20 March 2013. On 16 April 2013 he returned to informal patient status. He remained at Slade House from the date of his admission on 19 March until his death on 4 July 2013.

19. The Trust was told on admission about Connor's epilepsy and his January seizure, but his mother was not asked for any detailed information about his seizures and how they would present. The risk assessment on admission was inadequate and did not address the question of Connor's epilepsy or the risks attendant on it. Despite that, the Trust established a regime of observations every 10 minutes. Connor loved to take long baths; but no arrangements were made to ensure his safety. It should have been obvious that periodic observations provided no protection in between times. Put shortly, he should not have been left to bathe himself without close supervision. Instead, a Care Plan drawn up on 20 March 2013 relaxed the observation period from 10 minutes to 15 minutes when Connor was in the bath. The Trust's records, which are themselves unclear and inadequate, suggest that on 4 June 2013 the observation period was changed to be every 60 minutes. No sensible justification for such a change could be suggested, though it is right to say that evidence from staff at the unit suggests that the observation period in practice remained at every 15 minutes, at least while he was in the bath.

20. During his time on the unit, Connor had epileptic events which demonstrated that his condition was not well controlled. Those events should have triggered a review of his risk assessments or a different approach to managing the risks; but they did not. On 8 April 2013 his medication was changed by the introduction of Risperidone. That too should have triggered a reassessment of his risk assessments; but nothing was done. Instead, the introduction of Risperidone and the fact that it could interfere with his epilepsy medication was noted, with no adequate consideration being given to potential consequences or protections. On 20 May 2013 Connor complained to a staff nurse that he had a sore tongue. He said he would bite it when angry, which the nurse accepted. However, that same day his mother emailed the unit making plain her belief that Connor had had a seizure because she found he had bitten his lip and tongue and was very dozy when she visited him. Even with this information from his mother, there was no adequate investigation or reassessment. All that was done was to make enquiries about the availability of a new form of epilepsy monitor. Of six actions listed on 20 May, only one had been implemented by July 2013. On two subsequent occasions, his mother gave the Trust precise information which indicated that Connor

had had further seizures. The last occasion was on 1 July 2013, just two days before Connor's death. There were identifiable failures at every level, reflecting the inadequate systemic attention to matters of health and safety.

21. On the morning of 4 July 2013, Connor started his bath at about 08.30. He was checked at about 08.45 and 09.00. At about 09.20, when the next check was undertaken, Connor was found submerged and blue. Despite all attempts to revive him, he died. His death was entirely avoidable and both should and would have been avoided if basic principles for the care of vulnerable patients had been followed at any stage.

22. The inquest into Connor's death was not concluded until October 2015. When it was, the Jury concluded (on overwhelming evidence) that his death was "contributed to by neglect", meaning that there had been a gross failure to provide basic care for Connor and that the failure caused or was a significant cause of his death. The findings, which are accepted by the Trust, included:

    a. "…very serious failings, both in terms of systems in place to ensure adequate assessment, care and risk management of patients with learning disability at STATT and in terms of errors and omissions in relation to Connor's care whilst at STATT."

    b. "Contributing factors include: A lack of clinical leadership on the Unit; a lack of adequate training and provision of guidance for nursing staff in the assessment, care and risk management of epilepsy;"

    c. "A very serious failing was made in relation to Connor's bathing arrangements;"

    d. "Other failings included the failure to complete an adequate history of Connor's epilepsy and complete an adequate epilepsy risk assessment soon after admission;"

    e. "Evidence also exists of inadequate communication with Connor's family and between staff regarding Connor's epilepsy care needs and risks."

23. Other external reports reached the same or similar conclusions. I do not refer to them in any detail save to record that a Report by Dr Crawford, a Consultant Neurologist with specialist expertise on epilepsy, reached a series of conclusions that were highly critical of the Trust covering virtually every aspect of the lack of proper care for Connor. She identified a lack of epilepsy training for staff and the lack of any systems to ensure the safety of epileptic persons. In summary, she identified multiple management and organisational failures too many and too substantial to set out in detail in these sentencing remarks.

24. On the basis of the information that is now known, the Prosecution summarises the principal features of the case in the following terms:

    "1. As a matter of fact the Trust failed to ensure Connor's safety.

2. There was no Risk Assessment which addressed the hazard of unsupervised bathing for persons with epilepsy.
3. NICE Guidelines required a Risk Assessment to cover bathing. None was done.
4. The management system and standards did not require such a Risk Assessment to be carried out in the circumstances of this case.
5. The management on site did not provide appropriate supervision or monitoring.
6. There was no established bathing policy or procedure which required a Risk Assessment.
7. The named nurse given the task of preparing one, had had no training in the production of Epilepsy Management Plans.
8. The Risk Assessment was not reviewed after the episode on 20 May, when it was accepted that there was a real risk that Connor had had an epileptic seizure ie; his seizures had increased.
9. Those managing the Unit failed to recognise the need for a Risk Assessment review.
10. There was a lack of effective supervision or monitoring of the care provided to Connor.
11. An epilepsy specialist should have been involved to provide detailed guidance to those who were responsible for managing and conducting Connor's care, particularly after signs that he was or may have been having epileptic events in the Unit.
12. The intervals for monitoring Connor, during bathing, were inappropriate.
13. The Trust did not ensure that all relevant and helpful information connected with Connor's bathing regime was acquired from his family.
14. Staff dealing with Connor were insufficiently trained to recognise potentially significant aspects of his presentation, in terms of whether it could indicate an epileptic event, namely a so-called "partial" seizure.
15. Management failed to identity the training needs of the workforce, sufficient to meet the needs of patients with epilepsy.
16. The Trust failed to factor into Connor's care management the fact that changes in his medication increased the risk of an epileptic event."

25. The Trust expressly accepts each of these criticisms.

26. Victim Impact Statements from Dr Ryan and Dr Huggins make for almost unbearable reading. Dr Ryan describes how the light went out of her life on 4 July 2013. And in dignified and restrained terms she lays bare how the assertion by the Trust in the early days that Connor had died of natural causes compounded her grief. As did Mr Colvin when referring to the loss of TJ, Dr Huggins refers to their grief being raw. Their lives have become dominated by a deep, catastrophic and unspeakable pain, sadness and loss.

The Trust's Response

27. It is quite clear that the Trust now is a better organisation than it was in the period to July 2013, which is the period covered by these charges. Witness Statements from Dr Broughton, the present chief executive who joined the Trust in November 2017, and Mrs Anderson, the Trust's Finance Director, show that eventually the Trust set about

remedying the deep-rooted and systemic failures that these cases have disclosed. In its evidence and the mitigation advanced by Counsel at the hearing, the Trust started (as it should) by expressing deep regret and remorse about the long standing circumstances that gave rise to the avoidable deaths of TJ and Connor. It acknowledges that the deaths were entirely preventable and should never have occurred.

28. In the Trust's own words:

> "It is a matter of significant regret that between April 2011 and spring 2016 the Trust did not adequately address the quality and safety, governance and assurance challenges it faced in a timely and robust way."

29. From the perspective of the Court, it is not merely a matter of regret but of very grave concern that the endemic failures disclosed by the investigations following the avoidable deaths of TJ and Connor were allowed to arise at all and to persist for so long. That concern is heightened by the failure to have learned any lessons or to have addressed the systemic failures adequately or at all between April 2012 and July 2013, for which there appears to be no excuse at all.

30. That said, there is now an entirely new Board, and significantly changed and strengthened management within the Trust. None of the present Board were in post at the time giving rise to the present charges. It is not suggested that all is now perfect, but substantial evidence has been put before the Court to the effect that the Trust has now addressed the deficiencies in its health and safety management systems as it should and that, in the words of one observer, it has "turned the corner" so that the many people it serves can now have a degree of confidence in the Trust that was lost during the dark years of inadequate systems and management

31. The Trust in its submissions to the Court has frankly recognised the seriousness of the failings that have been disclosed by the investigations which followed the deaths of TJ and Connor. It starts by recognising that the deaths of TJ and Connor were both preventable and should not have occurred. It accepts the wide-ranging criticism made by the Prosecution in almost every respect.

32. In its own words:

> "the admitted failures include:
>
> a. The failure to ensure that [TJ] and [Connor] were provided with appropriate care – in short there were clinical and healthcare staff and wider Trust errors and failures and the Trust fully acknowledges that it breached its duty and failed to keep these 2 patients safe;
>
> b. There was insufficient risk analysis;
>
> c. There were failures in risk analysis;
>
> d. There were ineffective policies and procedures;
>
> e. There was ineffective and poor leadership;

f. There was a failure to respond to warnings and events in a timely and appropriate manner;

g. There were failures by healthcare staff to safely and appropriately supervise patients;

h. There was poor governance, poor documentation and a poor and worrying reporting practice when ‘things went wrong’ or were ‘flagged up’;

i. There were failures of supervision; and

j. Importantly, the Trust recognises that there was a failure to learn lessons and improve practice.

In summary, the Trust accepts that there were varied and wide ranging systems failures.”

33. There is significant mitigation that the Trust can advance, and has advanced without detracting from the fullness of its admissions. That mitigation is both general and specific to the risks with which these two charges are directly concerned.

34. Dealing with the specific risks first, the Trust has carried out thorough investigations into the short-comings in the Risk Assessments in both cases and has taken steps to ensure that such short-comings do not happen in future.

35. Turning first to ligature risks, the Trust has implemented wholesale changes in its approach to this critical risk issue, which are detailed in the witness statements of Dr Broughton and Mrs Anderson. The steps taken by the trust include investing £11.5million on ligature management works since 2013; the development since 2016 (and continuing) of a Ligature Management Work Plan designed to develop a strengthened approach to ligature risks; allocating responsibility at all levels up to Board level to ensure that there is a coherent and unified approach to ligature risk management; and introducing training so that by January 2018 98% of relevant Trust staff had completed mandatory ligature care e-training. Dr Broughton has told the Court that, in his opinion, the ligature risks that were apparent in 2012 would not be tolerated at the Trust today. That appears to be correct on the evidence presented by the Trust.

36. Turning to epilepsy risks, by the time of Connor’s death, the Trust had policies, procedures, guidance, toolkits and pathways for caring for learning disability service users with epilepsy. They were in place in its Hampshire learning disability services; but they had not been implemented in Oxfordshire. They now have been. In Professor Crawford’s opinion, had the Hampshire care pathway been in force in Oxfordshire, it is unlikely that Connor would have died as he did. This is distinctly two-edged: there is no obvious reason why the good practice of which the Trust was fully aware and implemented in part of its area could not have been applied in Connor’s case; on the other hand, the situation has now been improved. The Court has been told, and I accept, that there have been comprehensive changes in the management of patients with epilepsy since Connor’s death. Those changes include

changes in relation to risk assessments, physical assessment and monitoring, and the training of staff.

37. More generally, the Trust's governance arrangements for the management and elimination of risk have been substantially overhauled and strengthened, as set out in the Trust's evidence before the Court. It appears that, among other changes:

    a. since 2015 the Trust's health, safety and security team has more than doubled in size; and it is now appropriately resourced, staffed and qualified;
    b. out of the Trust's 6,000 staff team some 220 employees have specific and dedicated Health & Safety duties as part of their role. Routes for reporting issues of concern to the Board have been established;
    c. by December 2017, 99% of Trust staff had completed the Trust's Health and Safety training awareness course;
    d. responsibility for health and safety is clearly established at all levels from ward to Board;
    e. there has been a complete revision of the Trust's health and safety policies, procedures and arrangements.

38. I accept the Trust's evidence that it is now fully committed to providing and maintaining a safe environment for all patients and staff and others affected by the Trust's activities.

The Court's Approach to Sentencing

39. The Definitive Guideline for Health and Safety Offences, effective from 1 February 2016, lays down nine steps for the Court to follow unless the Court considers it contrary to the interests of justice to do so. I intend to follow the steps laid down in the Guideline, not least so that it may be completely apparent how and why I have come to the sentences that I shall impose. I note in passing that "Starting points and ranges apply to all offenders, whether they have pleaded guilty or been convicted after trial. Credit for a guilty plea is taken into consideration only after the appropriate sentence has been identified."

40. It is also important to identify at the outset that the Court is required to sentence for the offences with which the Trust has been charged and to which it has pleaded guilty. Each charge is time limited. The TJ Charge alleges a breach the duty imposed by s. 3 of the Act "on and before 22 April 2012" by failing to ensure so far as reasonably practicable the safety of patients including (but not limited to) TJ from the risk of serious self-harm in that ligature points and liagtures were present in a range of premises. The Connor Charge alleges a breach of the duty imposed by s. 3 of the Act "between 18th Day of March 2013 and 5th July 2013" by failing to ensure so far as reasonably practicable the safety of patients including (but not limited to) TJ from the risk of drowning from bathing."

41. Three things must be recognised as a result of the formulation of the charges to which the Trust has pleaded guilty. First, I am not required to arrive at a sentence to reflect all of the failings which have been identified in the course of the investigations that

have taken place. That does not mean that the serious and systemic failings to which I have referred are irrelevant. Far from it. They provide the context within which the specific breaches alleged in each charge occurred and, in large measure, explain how they came about and came to affect TJ and Connor respectively. They therefore demonstrate that the Court must not regard what happened to TJ and Connor as isolated instances or as failings that could be attributed to individual failures on the ward in either case.

42. Second, the seriousness of the charges is reflected in the fact that it was not only TJ and Connor who were affected by the breaches that have been charged, though that would have been bad enough. The Court must consider the extent of the risk to which patients were exposed and not just the facts relating specifically to TJ and Connor.

43. Third, the charges are directed to exposing patients to risk. It is not a necessary part of the offences that have been charged that either TJ or Connor was caused to die by the risks to which the Trust exposed its patients. However, the fact that the Trust's breaches of duty under each charge caused the avoidable deaths of TJ and Connor is a serious aggravating feature of each charge respectively.

The Sentence in the TJ Case

Step 1: offence category

44. The offence category is determined using only the culpability and harm factors in the table set out in the Guideline. In the TJ Case the culpability was high: the Trust fell far short of the appropriate standard by failing to put in place measures to address known risks, ignoring concerns raised by employees (specifically, Mr Holder), failing to make appropriate changes following many previous incidents exposing patients to the risks to health and safety of ligature risk including, most importantly, the risk from telephone cords and allowing breaches to continue for a long time. The payphone in question was identified in the November 2011 Risk Assessment as a risk, but it had been present long before then and the nature of the risk was not properly assessed. Finally, there was systemic failure within the organisation to address risks to health and safety from ligature points and ligatures in a range of locations. Subsequent enquiries disclosed that ligature points such as that which caused TJ's death were present in approximately 20 other locations across the Trust's estate in places that exposed patients to risk.

45. The presence of fixed ligature points, including about 20 other locations with telephone cords such as the one which caused TJ's death, gave rise to a risk of death or serious injury causing lifelong dependency on others. It is accepted by the Trust that Level A is the appropriate Level. The prosecution rightly accepts that the likelihood of Level A harm arising, when judged across the full range of the Trust's premises and events, is not high. The likelihood of Level A harm arising was medium, indicating that the case should at this point be regarded as Harm category 2.

46. The prosecution submits that, over a significant period before 22 April 2012 any patient with self-harming tendencies who was an inpatient at the Woodhaven Unit or in other units where similar risks were present would have been exposed to the risk. I accept the proposition in the abstract, but the Court does not know how many patients with relevant self-harming tendencies would have been exposed either to the risk from the Woodhaven payphone or from similar phone cords elsewhere. It is therefore not possible to make any reliable assessment or to reach any reliable conclusion about the numbers at risk or the scale of risk overall.

47. The Guideline requires the Court to consider whether the offence was a significant cause of harm. In TJ's case it was, lethally so.

48. In the light of these conclusions I must consider moving the offence up a harm category or moving it up substantially within the category indicated. I accept the submission of the prosecution that the fact of causing a fatal accident may itself be good grounds for moving up a category. There is a risk of double-counting where systemic failings contributes to a finding of high culpability and might arise again at the present stage. In my judgment, much the most important feature to bring in at this stage is the avoidable death of TJ in circumstances where the Trust had identified the phone cord as an actual risk, had under-assessed the level of risk that it posed under its scoring system and had ignored the warnings of Mr Holder. In this context, which I have outlined more fully at an earlier stage in these remarks, I consider that causing the death of TJ both justifies and requires that the offence be moved up a category to Harm Category 1. I am influenced in this judgment by the fact that, even without the occurrence of a fatality, the case would come within the upper part of the Harm Category 2 range because of the features I have already identified.

Step 2: Starting point and category range

49. The Trust is a large organisation with an "income" of c. £300 million. This figure only gives a small part of the picture. As with other NHS bodies, the Trust has been under significant financial pressure to improve services in an environment of budgetary constraints. Mrs Anderson gives evidence of robust financial management but, even so, the Trust was left with a small deficit in 2014/2105 and 2015/2016. It achieved a surplus in 2016/2017 thanks to grant funding. In each of this and the next financial years it is required to make savings of £10-12 million per annum, equivalent to savings of about 4.3% of budget. As things stand, it is far from certain that the Trust will meet its financial targets this year. If it fails to do so it will lose grant funding, further exacerbating its financial position. As further mitigation, the Trust points to the substantial capital investment it has made on health and safety in recent years, some of which I have detailed earlier. The picture overall is of a body with a large turnover that faces considerable financial challenges if it is to break even while delivering the services that the public rightly expect.

50. Moving away from the financial background, the fact that the Trust's breaches were most likely to affect vulnerable patients is an aggravating factor. I have already taken

the duration of the breach and the failure to react to either knowledge of or warnings about risk into account and do not treat them as separate aggravating features at this stage. In mitigation the Trust may point to:

a. The absence of previous relevant convictions;

b. The evidence of the substantial steps that the Trust has taken to put its house in order;

c. The Trust's high level of cooperation with the HSE investigation; and

d. It present acceptance of responsibility.

51. Bringing all of these factors into the balance, High culpability and harm category 1 indicates a starting point of £2,400,000 with a category range from £1,500,000 to £6,000,000. The relative inflexibility of the Trust's ability to manage income and expenditure and the lack of any surplus funds despite robust financial management should, if anything, tend to moderate the Court's approach to the Trust's ability to pay a very substantial fine. The vulnerability of the Trust's patients is a feature that runs throughout this exercise, contributing to the assessment of culpability and the extent of the risk; and, in my judgment, caution should be exercised before applying any substantial additional weighting factor at this stage. As against that, while I do not forget the intransigence that was faced by the families in the early days, the Trust's conduct more recently is substantial mitigation.

52. For these reasons, I consider that the balance of the financial, aggravating and mitigating factors to which I have referred indicate a point towards the lower end of the category range, which at this point I would identify as being a fine of £1,750,000.

Step 3: Check whether the proposed fine based on turnover is proportionate to the overall means of the offender

53. The Court is reminded that a fine must be "sufficiently substantial to have a real economic impact which will bring home to both management and shareholders the need to comply with health and safety legislation." The Trust has stakeholders but not shareholders. I am satisfied that the Trust's present management are fully conscious of the need to comply with health and safety legislation and that they have taken substantial steps to try to do so. Whether a fine of this order (or any fine) will influence conduct elsewhere is for others to judge. Taken on its own, I am satisfied that a fine of £1,750,000 is sufficiently substantial. My concern arises from the inflexibility of the Trust's financial structure and constraints and the fact that every pound paid as a fine will be a pound less that is available for clinical care going forward. This gives rise to an inevitable tension between the need to hold the Trust accountable for what has happened in the past and the need to recognise its essential function in spending public funds for the public good in the future. The Trust is not a profit-making organisation and, so far as I can see, derived no economic benefit from the offence apart from any savings that had been made by not investing sufficiently seriously in matters of health and safety. Such a fine will not put the Trust out of

business though, as I have said, it will impact on its ability to deliver clinical health services in the future. Standing back, and subject to what I say later, I am satisfied that a fine of the order indicated would satisfy the general principles identified in the Guideline.

Step 4: Other factors

54. The Guideline states that where, as here, the fine will fall on public bodies, the fine should normally be substantially reduced if the offending organisation is able to demonstrate the proposed fine would have a significant impact on the provision of its services. Although the Trust has provided substantial evidence to show what it has now invested in its health and safety management systems, and although I have accepted both that the Trust operates under financial constraints, and that it has no apparent surplus funds available, and that the imposition of any fine will reduce the sums available for clinical services pro rata, the Trust's evidence does not demonstrate that particular services will or will not be affected by a given level of fine. I am aware that others have imposed a reduction of as much as 50% on the facts of the particular case: see, for example, the sentencing remarks of Haddon-Cave J in the case of R v Shrewsbury and Telford NHS Trust, 28 November 2017. It is not immediately apparent how the 50% figures was reached, though I note that the Defendant Trust in that case was running a more substantial deficit year on year than the Trust in the present case. I also note that the reduction was applied after discount for plea, which the Guideline places later at Step 6. In my judgment, it would be appropriate to revisit this question under the heading of totality once the fines that would be otherwise be imposed under both counts are known.

Step 5: Consider other factors which indicate a reduction

55. The Trust submits that it is now a very different organisation and is one which now takes its health and safety responsibilities seriously and has invested appropriately to remedy the failings of the past. I accept the general thrust of that submission but have already taken it into account under step 2. I do not consider it appropriate to make a further reduction at this stage.

Step 6: Reduction for guilty plea

56. I give full credit of 1/3 for the Trust's early indication of its intention to plead guilty. This reduces the proposed level of fine to £1,150,000.

Steps 7, 8 and 9

57. I return to these steps after considering the sentence in Connor's Case.

The Sentence in Connor's Case

Step 1: offence category

58. It is accepted by the Trust that in Connor's case the culpability was high, the Harm Level was level 1 and that Harm Category was 1. It is rightly submitted by the

prosecution that the Trust's culpability is increased by its failure to take any steps to address the inadequacies of its health and safety management systems following the death of TJ and the warnings from Mr Holder (which went wider than ligature risks) that highlighted the deficient state of those systems.

59. As in TJ's Case, the offence was the cause of lethal harm. I am not able to assess how many vulnerable patients were exposed to the same risk of harm as Connor. It would be relevant to such an assessment that the Trust had implemented suitable epilepsy care pathways across part of its estate, which would have reduced or removed the risk to others.

60. In the light of these conclusions I must consider moving the offence up substantially within Harm Category 1. I consider that causing the death of Connor both justifies and requires that the offence be moved up within Harm Category 1.

Step 2: Starting point and category range

61. I repeat what I have said earlier about the Trust's financial background.

62. Moving away from the financial background, the fact that the Trust's breaches were most likely to affect vulnerable patients is an aggravating factor. I have already taken the Trust's failure to react to its various "wake-up calls" into account and do not treat them as separate aggravating features at this stage. Once again, in mitigation the Trust may point to:

    a. The absence of previous relevant convictions, though this is tempered to some extent by its failure to react to the death of TJ;

    b. The evidence of the substantial steps that the Trust has taken to put its house in order;

    c. The Trust's high level of cooperation with the HSE investigation; and

    d. It present acceptance of responsibility.

63. Bringing all of these factors into the balance, High culpability and harm category 1 again indicates a starting point of £2,400,000 with a category range from £1,500,000 to £6,000,000. The relative inflexibility of the Trust's ability to manage income and expenditure and the lack of any surplus funds despite robust financial management should again, if anything, tend to moderate the Court's approach to the Trust's ability to pay a very substantial fine. The vulnerability of the Trust's patients is a feature that runs throughout this exercise, contributing to the assessment of culpability and the extent of the risk; and, in my judgment, caution should be exercised before applying any substantial additional weighting factor at this stage. As against that, while I once again I refer to the intransigence that was faced by the families in the early days, the Trust's conduct more recently is substantial mitigation.

64. For these reasons, I consider that the balance of the financial, aggravating and mitigating factors to which I have referred indicate a fine of £2,000,000.

Step 3: Check whether the proposed fine based on turnover is proportionate to the overall means of the offender

65. I refer to what I said earlier under Step 3 in the TJ Case. Taken on its own, I am satisfied that a fine of £2,000,000 is sufficiently substantial. Once again, my concern arises from the inflexibility of the Trust's financial structure and constraints and the fact that every pound paid as a fine will be a pound less that is available for clinical care going forward. As before, such a fine will not put the Trust out of business though, as I have said, it will impact on its ability to deliver clinical health services in the future. Standing back, and subject to what I say later, I am satisfied that a fine of the order indicated would satisfy the general principles identified in the Guideline.

Step 4: Other factors

66. Once again the question posed by the Guideline is whether the Trust is able to demonstrate that the proposed fine would have a significant impact on the provision of its services. As before, the Trust's evidence does not demonstrate that particular services will or will not be affected by a given level of fine. Once again, in my judgment, it would be appropriate to revisit this question under the heading of totality once the fines that would otherwise be imposed under both counts are known.

Step 5: Consider other factors which indicate a reduction

67. I repeat what I said under previously.

Step 6: Reduction for guilty plea

68. I give full credit of 1/3 for the Trust's early indication of its intention to plead guilty. This reduces the proposed level of fine to £1,333,000.

Steps 7, 8 and 9

69. No question of orders for remediation, forfeiture or compensation arise.

70. Although neither the Prosecution nor the Trust advanced detailed submissions in relation to Totality, the Guideline requires that it be considered. The point reached thus far is the potential imposition of two fines totalling just under £2,500,000. In my judgment two separate questions fall to be asked and answered:

    a. Are aggregate fines of just under £2,500,000 after full reduction for plea just and proportionate to the offending behaviour? And

    b. Should the aggregate fines be adjusted at this stage to take into account the fact that the Trust is a public body delivering health services in challenging financial circumstances?

71. In answering the first question, it is right to take into account that the seriousness of the charge in the Connor Case derives in substantial part from the same systemic failings as gave rise to the TJ Case. If a broad view is taken of the matters before the Court, it is not unreasonable to see them as a single course of serious failure by

management to take health and safety management systems seriously, which is substantially aggravated by the avoidable deaths of two vulnerable patients. Viewed in that way, it seems to me to be arguable that an aggregate fine of less that £3,500,000 before plea could be regarded as just and proportionate on totality grounds.

72. Consideration of the second question, in my judgment, tends to the same answer: namely that there should be a reduction in the case of a public body, now substantially reformed, which is engaged in delivery of important medical services for some of the most vulnerable in society.

73. Before announcing my final decision, I wish to pay public tribute to the dignity of those who have sat through these proceedings, watching their personal tragedy being examined under the cold light of Health and Safety Legislation.

Sentence

74. For the reasons I have set out in these sentencing remarks, I shall reduce the aggregate fine imposed by reference to the questions of totality that I have just discussed. The end result is reached by reference to my overall conclusion on totality grounds that the aggregate fine to be paid by the Trust is one of £2,000,000. In my judgment a just and proportionate outcome that marks the seriousness of the Trust's offending, the terrible consequences of that offending, and the other material factors that I have indicated is as follows:

    a. On the TJ Charge, the fine will be £950,000

    b. On the Connor Charge, the fine will be £1,050,000

    c. The Trust will pay the Prosecution's costs in the sum that has been agreed. Failing agreement, I will hear submissions.

    d. I will hear submissions on the time for payment.